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DATE NOTICE SENT TO ALL PARTIES: Dec/18/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Active physical medicine 3 x/week for 2 weeks to the right shoulder

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Internal Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of the reviewer that the request for active physical medicine 3 x/week for 2 weeks to the right shoulder is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is XX/XX/XX. Initial medical report dated XX/XX/XX indicates that he went inside and the door came off the hinges and he propped it back and started operating. The patient slowed due to an upcoming stop when the door started to fall on him, he turned his body to the right to stop it, but it still fell on him. He subsequently developed back and right shoulder pain. Initial diagnoses are right shoulder sprain/strain and lumbar sprain/strain. Subsequent medical report dated 09/02/15 indicates that he is attending approved therapy sessions. On physical examination range of motion of the right shoulder is flexion 170, abduction 160, extension 15, IR 40 and ER 50 degrees. Strength is 3+/5. Subsequent medical report dated 09/29/15 indicates that there is tenderness to palpation of the right shoulder. Range of motion is flexion 170, abduction 170, extension 15, IR 30 and ER within normal limits. Strength is 4-/5.

The initial request for active physical medicine 3 x week for 2 weeks to the right shoulder was non-certified on XX/XX/XX noting that there is no documented reason why these therapies could not have been done concurrently. Request for reconsideration dated XX/XX/XX indicates that the patient can demonstrate improvements of pain level, AROM, strength and tolerance and performance of lifting, pushing, pulling and overhead activities. He has not yet reached his pre-injury functional level. The denial was upheld on appeal dated XX/XX/XX noting that the patient had PT that exceeded ODG. The treatment of the L-spine should have been done concurrently with the shoulder.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries to the right shoulder and low back on XX/XX/XX when a door fell on him. The patient has completed at least 10 physical therapy visits to date for diagnoses of right shoulder sprain/strain and lumbar sprain/strain. The Official Disability Guidelines support up to 10 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery

documented. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. As such, it is the opinion of the reviewer that the request for active physical medicine 3 x/week for 2 weeks to the right shoulder is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)